SERFF Tracking Number:	*CHUB-125611628*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#370190 $70*
Company Tracking Number:	*DO AR0040510F01*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1006 Directors & Officers Liability*
Product Name:	*Health Care Portfolio*		
Project Name/Number:	*HCP/405*		

Filing at a Glance

Company: Federal Insurance Company

Product Name: Health Care Portfolio	SERFF Tr Num: CHUB-125611628	State: Arkansas
TOI: 17.1 Other Liability - Claims Made Only	SERFF Status: Closed	State Tr Num: #370190 $70
Sub-TOI: 17.1006 Directors & Officers Liability	Co Tr Num: DO AR0040510F01	State Status: Fees verified and received
Filing Type: Form	Co Status:	Reviewer(s): Betty Montesi, Edith Roberts, Brittany Yielding
	Authors: Donna Daigle, Lois Schroeder, Desirae Bartlett	Disposition Date: 05/23/2008
	Date Submitted: 05/02/2008	Disposition Status: Approved

Effective Date Requested (New): On Approval
Effective Date (New):
Effective Date Requested (Renewal): On Approval
Effective Date (Renewal):

State Filing Description:

General Information

Project Name: HCP	Status of Filing in Domicile: Pending
Project Number: 405	Domicile Status Comments:
Reference Organization: na	Reference Number: na
Reference Title: na	Advisory Org. Circular: na
Filing Status Changed: 05/23/2008	
State Status Changed: 05/23/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

We are filing 2 new applications for this product. The product was approved by the Department effective September 22, 2004 under our filing designation number DO AR0023101F01

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*CHUB-125611628*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#370190 $70*
Company Tracking Number:	*DO AR0040510F01*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1006 Directors & Officers Liability*
Product Name:	*Health Care Portfolio*		
Project Name/Number:	*HCP/405*		

Donna Daigle, State Filing Analyst
82 Hopmeadow Street
Simsbury, CT 06070-7683

ddaigle@chubb.com
(800) 464-7965 [Phone]
(860) 408-2047[FAX]

Filing Company Information

Federal Insurance Company	CoCode: 20281	State of Domicile: Indiana
202 Hall's Mill Road	Group Code: 38	Company Type:
P.O. Box 1650		
Whitehouse Station, NJ 08889-1650	Group Name:	State ID Number:
(908) 572-4726 ext. [Phone]	FEIN Number: 13-1963496	

SERFF Tracking Number:	*CHUB-125611628*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#370190 $70*
Company Tracking Number:	*DO AR0040510F01*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1006 Directors & Officers Liability*
Product Name:	*Health Care Portfolio*		
Project Name/Number:	*HCP/405*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$70.00
Retaliatory?	Yes
Fee Explanation:	35 per form x 2 forms
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Federal Insurance Company	$0.00	05/02/2008	

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
00370190	$70.00	04/18/2008

SERFF Tracking Number:	*CHUB-125611628*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#370190 $70*
Company Tracking Number:	*DO AR0040510F01*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1006 Directors & Officers Liability*
Product Name:	*Health Care Portfolio*		
Project Name/Number:	*HCP/405*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	05/23/2008	05/23/2008

SERFF Tracking Number:	*CHUB-125611628*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#370190 $70*
Company Tracking Number:	*DO AR0040510F01*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1006 Directors & Officers Liability*
Product Name:	*Health Care Portfolio*		
Project Name/Number:	*HCP/405*		

Disposition

Disposition Date: 05/23/2008
Effective Date (New):
Effective Date (Renewal):
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CHUB-125611628*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#370190 $70*
Company Tracking Number:	*DO AR0040510F01*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1006 Directors & Officers Liability*
Product Name:	*Health Care Portfolio*		
Project Name/Number:	*HCP/405*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Form	Health Care Portfolio for Physicians & Surgeons New Business Application	Approved	Yes
Form	Health Care Portfolio for Physicians & Surgeons Renewal Business Application	Approved	Yes

SERFF Tracking Number:	*CHUB-125611628*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#370190 $70*
Company Tracking Number:	*DO AR0040510F01*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1006 Directors & Officers Liability*
Product Name:	*Health Care Portfolio*		
Project Name/Number:	*HCP/405*		

Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Health Care Portfolio for Physicians & Surgeons New Business Application	14-03-0967	04/2008	Application/ New Binder/Enro llment		0.00	14-03-0967.pdf
Approved	Health Care Portfolio for Physicians & Surgeons Renewal Business Application	14-03-0968	04/2008	Application/ New Binder/Enro llment		0.00	14-03-0968.pdf

Chubb Group of Insurance Companies
15 Mountain View Road
Warren, New Jersey 07059

Health Care Portfolio SM
for Physicians & Surgeons
New Business Application
(For organizations with up to 250 employees)

BY COMPLETING THIS APPLICATION YOU ARE APPLYING FOR COVERAGE WITH FEDERAL INSURANCE COMPANY (THE "COMPANY")

NOTICE: THE LIABILITY COVERAGE SECTIONS OF HEALTH CARE PORTFOLIO PROVIDE CLAIMS-MADE COVERAGE, WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD", OR ANY APPLICABLE EXTENDED REPORTING PERIOD. THE LIMIT OF LIABILITY TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY "DEFENSE COSTS", AND "DEFENSE COSTS" WILL BE APPLIED AGAINST THE RETENTION AMOUNT. IN NO EVENT WILL THE COMPANY BE LIABLE FOR "DEFENSE COSTS" OR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT IN EXCESS OF THE APPLICABLE LIMIT OF LIABILITY. READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

APPLICATION INSTRUCTIONS:

Whenever used in this Application, the term "**Applicant**" shall mean the Parent Organization and all subsidiaries, unless otherwise stated.

I. GENERAL INFORMATION:

1. Name of **Applicant**: _____

2. Address of **Applicant**: _____

   City: _____ State: _____ Zip Code: _____ Telephone: _____

   Website: _____

3. State and Date of Incorporation: _____

4. Authorized individual (Executive Officer) to receive notices and information regarding the proposed coverage sections:

   Name: _____ Title: _____

   E-Mail Address: _____ Phone: _____ Fax: _____

5. Individual responsible for Human Resources or employment law matters:

   Name: _____ Title: _____

   E-Mail Address: _____ Phone: _____ Fax: _____

II. SPECIFIC INFORMATION:

1. Please indicate below which coverages are being requested and complete supplemental questionnaires if required.

Note: The requested coverage is not automatically provided; the terms and conditions of the coverage section, if issued, will determine actual coverage.

Coverage Requested	Limit of Liability Requested	Retention Requested
☐ Directors & Officers Liability	$	$
☐ Optional Entity Liability	$	$
☐ Optional Employment Practices Liability	$	$
☐ Optional Third Party Liability	$	$
☐ Fiduciary Liability		
☐ Optional Separate Defense Costs Coverage	$	$
☐ Crime	$	$
☐ Kidnap/Ransom & Extortion	$	$

2. Describe nature of **Applicant's** business: _____

3. **Applicant** is a: ☐ Not-For-Profit Tax Exempt Corp. ☐ For-Profit Corp.
   ☐ Not-For-Profit Taxable Corp. ☐ Limited Liability Company
   ☐ Partnership ☐ Other (describe):_____

4. Please complete the following information:
   (a) Revenues: Previous twelve (12) months: _____ Projected next twelve (12) months: _____
   (b) Employees: Previous twelve (12) months: _____ Projected next twelve (12) months: _____
   (c) Total Assets: _____

5. Does the **Applicant** have any subsidiaries**,** joint ventures or affiliates or control any other entity or organization? ☐ Yes ☐ No
   If "Yes," please attach a description of the operations, ownership, and the tax status of each such entity, and indicate whether coverage is requested for each such entity.

6. **Applicant's** Accreditation (note all that apply): ☐ JCAHO ☐ NCQA ☐ Other_____

7. Has the **Applicant** in the past eighteen (18) months completed or agreed to, or does it contemplate during the next twelve (12) months, any of the following, whether or not such transactions were or will be completed:
   (a) Reorganization or arrangement with creditors under federal or state law? ☐ Yes ☐ No
   (b) Branch, location, facility, office, or subsidiary closings, consolidations or layoffs? ☐ Yes ☐ No
   (c) Mergers or acquisitions? ☐ Yes ☐ No
   If "Yes" to any part of Question 7, please describe the essential terms of each such transaction as an attachment.

III. DIRECTORS AND OFFICERS LIABILITY INFORMATION:

1. Does the **Applicant** now have tax exempt status under applicable federal, state and local law, including the U.S. Internal Revenue Code of 1986, as amended? ☐ Yes ☐ No
   If "Yes," is any challenge to the **Applicant's** tax-exempt status pending or anticipated by any party, private or governmental? ☐ Yes ☐ No
   If "Yes," please explain: _____

2. Has the **Applicant** or any person proposed for coverage been the subject of, or been involved in, any of the following during the past five (5) years:

	Organization	**Persons**
(a) Anti-trust, copyright or patent litigation?	☐ Yes ☐ No	☐ Yes ☐ No
(b) Civil, criminal or administrative proceeding alleging violation of any federal or state securities laws?	☐ Yes ☐ No	☐ Yes ☐ No
(c) Any other criminal actions?	☐ Yes ☐ No	☐ Yes ☐ No

   If "Yes" to any of the above in Question 2, please attach a full description of the details.

3. Other than those identified in your response to Question 2, has any civil proceeding been brought at any time during the last five (5) years against (a) any **Applicant** or (b) any proposed insured individual in his or her capacity as a director, officer, trustee or member of any duly constituted committee of any entity? ☐ Yes ☐ No
   If "Yes," please attach a full description of the details.

4. Please complete the following information:

Names of Director or Officer Shareholders	Voting Shares Owned
	%
	%
Shareholders (include individual and corp. names) who are both non-directors and non-officers owning 5% or more of voting shares	Voting Shares Owned
	%
	%

5. In the next twelve (12) months (or during the past two (2) years) is the **Applicant** contemplating (or has the **Applicant** completed or been in the process of completing) any public or private offering of securities or issuance of debt? ☐ Yes ☐ No

   If "Yes," please attach a full description of the details, including a copy of any prospectus.

6. Does the **Applicant** have written policies and procedures in place for provider selection, including credentialing, re-credentialing, and making decisions that adversely affect a provider's credentials?

   (a) for self? ☐ Yes ☐ No

   (b) for others for a fee? ☐ Yes ☐ No

   (c) are such policies and procedures in compliance with JCAHO or NCQA guidelines? ☐ Yes ☐ No

   If "No," provide details by separate attachment.

7. Does the **Applicant** control more than twenty percent (20%) in any given geographical area of:

   (a) providers in any given field of practice; (b) hospital beds; (c) health care services; or (d) if the **Applicant** provides managed care products or services, the market share of health plan members? ☐ Yes ☐ No

   If "Yes" to Question 7(a), (b), (c) or (d), please provide market share percentages by separate attachment.

8. (a) Name of Compliance Officer and title: _____

   (b) Does the Compliance Officer have direct access to the CEO or board? _____

9. Compliance Program in effect? ☐ Yes ☐ No

   If Yes, date implemented? _____

   If Yes, please submit copy of Compliance Program.

10. In the past 5 years, has any **Applicant** proposed for this insurance:

    (a) been subjected to any type of audit investigating whether it allegedly:

    (i) received overpayments for services provided, or ☐ Yes ☐ No

    (ii) violated any law ? ☐ Yes ☐ No

    (b) entered into a criminal or civil settlement with the United States or with some party acting on behalf of the United States by which claims against such **Applicant** were resolved? ☐ Yes ☐ No

    If Yes to Question 10(a) or (b), please explain: _____

IV. EMPLOYMENT PRACTICES LIABLITY AND THIRD PARTY LIABILITY INFORMATION: Complete if coverage is requested.

1. Number of Employees and Independent Contractors:

		Current Year	**Previous Year**
(a)	Full-time employees:	_____	_____
(b)	Part-time employees (include leased and seasonal):	_____	_____
(c)	Volunteers:	_____	_____
(d)	Employed Physicians:	_____	_____
(e)	Independent Contractors:	_____	_____
(f)	Employees located in California:	_____	_____

2. Does the **Applicant** have written procedures in place regarding:

(a) Equal Opportunity Employment: ☐ Yes ☐ No

(b) Anti-discrimination: ☐ Yes ☐ No

(c) Anti-harassment: ☐ Yes ☐ No

If "No" to any of the above, please attach a full explanation.

3. During the past 3 years, has any **Applicant** or any person proposed for coverage been involved in any capacity in any of the following matters?

(a) EEOC, NLRB or other similar administrative proceeding? ☐ Yes ☐ No

(b) Employment-related civil suit? ☐ Yes ☐ No

If "Yes" to either of the above in Question 3, please attach a full description of the details.

V. FIDUCIARY LIABILITY COVERAGE INFORMATION: Complete if coverage is requested.

1. Please list the names and types of **Applicant's** employee benefits plan(s). Attach additional pages if needed.

Plan names (Do not include health & welfare plans)	**Plan assets** (current year)	**Plan assets** (previous year)	**Type of plan***	**Underfunded by more than 25%?** (DB only)	**Number of plan participants**

* Defined Contribution (DC), Defined Benefit (DB), Employee Stock Ownership (ESOP), Excess Benefit or Top Hat EBP)

2. Does the **Applicant** handle any investment decisions in-house? ☐ Yes ☐ No

If "Yes," please describe: _____

3. In the past two (2) years, has the **Applicant** merged or terminated any plan(s)? ☐ Yes ☐ No

If "Yes," please attach details including transaction date, status of asset distribution, whether similar benefits are being offered, and name of insurance carrier if terminated plan benefits are secured by insurance.

4. Are any plans NOT in compliance with plan agreements or ERISA? ☐ Yes ☐ No

If "Yes," please explain: _____

5. Past activities:

   (a) Has any fiduciary been:

   (i) accused, found guilty or held liable for a breach of trust? ☐ Yes ☐ No

   (ii) convicted of criminal conduct? ☐ Yes ☐ No

   (b) Have any claims (other than for benefits) been made during the past three (3) years against any benefit program or any current or past fiduciaries? ☐ Yes ☐ No

   (c) Has there been any assessment of fees, fines or penalties under any voluntary compliance resolution program or similar voluntary settlement program administered by the IRS, DOL or other government authority against any plan? ☐ Yes ☐ No

   If "Yes" to any of the above in Question 5, please attach a full description of the details.

VI. CRIME COVERAGE INFORMATION: Complete if coverage is requested.

1. Does the **Applicant** allow the employees who reconcile the monthly bank statements to also sign checks or handle deposits? ☐ Yes ☐ No

   If "Yes," please explain: _____

2. What is the limit above which the **Applicant** requires countersignature for their checks? $_____

3. Please describe the services the **Applicant** provides for clients (including, but not limited to, accounting, payroll or purchasing functions): _____

4. Number of: domestic locations: _____; foreign locations: _____ and countries _____

5. Does the **Applicant** perform pre-employment reference checks for all its potential employees? ☐ Yes ☐ No

6. List all employee theft, forgery, computer fraud or other crime losses discovered by the **Applicant** in the last 5 years, itemizing each loss separately. Include date of loss, description and total amount of loss. (Attach additional pages if necessary.) _____

_____

VII. KIDNAP/RANSOM & EXTORTION COVERAGE INFORMATION: Complete if coverage is requested.

1. Please complete the following regarding **Applicant's** risk profile:

List countries in which you have operations	Type of operation	Number of locations	Number of employees	Revenues
U.S. and Canada				$
				$
				$
	TOTAL:			$

2. Please complete the following information regarding the foreign travel of the **Applicant's** employees:

Travel destination by country	Number of annual trips	Average length of stay	Number of employees traveling

3. Does the Applicant have a nursery, pediatric floor and/or an on-site child care/day care center? ☐ Yes ☐ No
   If "Yes," provide a brief description by separate attachment of the security measures used to ensure their safety.

4. Has the **Applicant** had any incidents or threats with respect to infant abductions during the past five (5) years? ☐ Yes ☐ No
If "Yes," please provide details by separate attachment.

5. List all kidnapping, extortion threat, cyber extortion, hijacking, wrongful detention or political threat events discovered by the **Applicant** in the last five (5) years, which would have been covered under the policy for which this **Application** is made, itemizing each loss separately. Include date of loss, threat or event; description of the loss, threat or event; and total amount of each loss. Attach additional pages if necessary. _____

VIII. CURRENT INSURANCE INFORMATION:

Coverage Sections	The Applicant currently purchases this coverage		Current Limit of Liability	Current Retention	Premium	Current Carrier
	Yes	No				
Directors & Officers And Entity Liability			$	$	$	
Employment Practices Liability and Third Party Liability			$	$	$	
Fiduciary Liability			$	$	$	
Crime			$	$	$	
Kidnap Ransom & Extortion			$	$	$	
Medical Professional Liability			$	$	$	
Managed Care Errors & Omissions			$	$	$	

IX. CLAIMS AND REPRESENTATIONS/PRIOR KNOWLEDGE OF FACTS/CIRCUMSTANCES:

1. During the past five (5) years, neither the **Applicant** nor any individual or entity proposed for coverage has submitted any claims or given notice of any fact, circumstance, situation, transaction, event, act, error, or omission which they had reason to believe might or could reasonably be foreseen to give rise to a claim that might fall within the scope of insurance with any insurer or self-insurance instrument of which the requested coverages would be a direct or indirect replacement, except as follows:

   If the answer is none, so state: _____

   NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE COMPANY, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 1 IS EXCLUDED FROM THE PROPOSED INSURANCE, AND THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 1 IS EXCLUDED FROM THE PROPOSED INSURANCE.

2. Neither the **Applicant** nor any individual or entity proposed for coverage is aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance, except as follows:
   If the answer is none, so state: _____

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE COMPANY, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 2 IS EXCLUDED FROM THE PROPOSED INSURANCE.

X. MATERIAL CHANGE:

If there is any material change in the answers to the questions in this Application before the policy inception date, the **Applicant** must immediately notify the Company in writing, and any outstanding quotation may be modified or withdrawn.

XI. DECLARATIONS, FRAUD WARNINGS AND SIGNATURES:

The **Applicant's** submission of this Application does not obligate the Company to issue, or the **Applicant** to purchase, any coverage section. The **Applicant** will be advised if the Application for coverage is accepted. The **Applicant** hereby authorizes the Company to make any inquiry in connection with this Application.

The undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare that to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application and in any attachments or other documents submitted with this Application are true and complete. The undersigned agree that this Application and such attachments and other documents shall be the basis of the contract should any coverage section providing the requested coverage be issued; that all such materials shall be deemed to be attached to and shall form a part of any such coverage section; and that the Company will have relied on all such materials in issuing any such coverage section.

The information requested in this Application is for underwriting purposes only and does not constitute notice to the Company under any insurance of a Claim or potential Claim.

Notice to Arkansas, Louisiana, Maryland, Minnesota, New Mexico and Ohio Applicants: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory agencies.

Notice to District of Columbia Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Notice to Florida and Oklahoma Applicants: Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of: a felony (in Oklahoma) or a felony of the third degree (in Florida).

Notice to Kentucky Applicants: Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

Notice to Maine, Tennessee, Virginia and Washington Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to Oregon and Texas Applicants: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Notice to Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to Puerto Rico Applicants: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Notice to New York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to: a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

This Application must be signed by the chief executive officer and chief financial officer of the Parent Organization acting as the authorized representatives of the person(s) and entity(ies) proposed for this insurance.

Date	Signature*	Title
_____	_____	Chief Executive Officer

XII. PLEASE ATTACH A COPY OF THE FOLLOWING REQUIRED INFORMATION FOR EVERY APPLICANT SEEKING COVERAGE:

- ☐ The most recent annual financial statements, audited if outside audits are performed.
- ☐ When requesting Executive Liability coverage, board or directors, trustees, managers or equivalent listing;
- ☐ Most recent audited pension financial statements for each defined benefit plan (applicable to Fiduciary Liability coverage only);
- ☐ Copy of employee handbook (applicable when requesting Employment Practices Liability coverage).

Produced By:

Agent: _____ Agency: _____

Agency Taxpayer ID or SS No.: _____ Agent License No.: _____

Address: _____

City: _____ State: _____ Zip: _____

Submitted By:

Agency: _____

Agency Taxpayer ID or SS No.: _____ Agent License No.: _____

Address: _____

City: _____ State: _____ Zip: _____

Chubb Group of Insurance Companies
15 Mountain View Road
Warren, New Jersey 07059

Health Care Portfolio℠
for Physicians & Surgeons
Renewal Application

BY COMPLETING THIS RENEWAL APPLICATION YOU ARE APPLYING FOR COVERAGE WITH FEDERAL INSURANCE COMPANY (THE "COMPANY")

NOTICE: THE LIABILITY COVERAGE SECTIONS OF HEALTH CARE PORTFOLIO PROVIDE CLAIMS-MADE COVERAGE, WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD", OR ANY APPLICABLE EXTENDED REPORTING PERIOD. THE LIMIT OF LIABILITY TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY "DEFENSE COSTS", AND "DEFENSE COSTS" WILL BE APPLIED AGAINST THE RETENTION AMOUNT. IN NO EVENT WILL THE COMPANY BE LIABLE FOR "DEFENSE COSTS" OR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT IN EXCESS OF THE APPLICABLE LIMIT OF LIABILITY. READ THE ENTIRE RENEWAL APPLICATION CAREFULLY BEFORE SIGNING.

RENEWAL APPLICATION INSTRUCTIONS

Whenever used in this Renewal Application, the term "**Applicant**" shall mean the Parent Organization and all subsidiaries, unless otherwise stated.

I. GENERAL INFORMATION:

1. Name of **Applicant**: _____

2. Address of **Applicant**: _____

   City: _____ State: _____ Zip Code: _____ Telephone: _____

   Website: _____

3. State and Date of Incorporation: _____

4. Authorized individual (Executive Officer) to receive notices and information regarding the proposed coverage sections:

   Name: _____ Title: _____

   E-Mail Address: _____ Phone: _____ Fax: _____

5. Individual responsible for Human Resources or employment law matters:

   Name: _____ Title: _____

   E-Mail Address: _____ Phone: _____ Fax: _____

II. SPECIFIC INFORMATION:

1. Please indicate below which Health Care Portfolio℠ coverages for which the **Applicant** seeks renewal:

   - ☐ Directors & Officers Liability
     - ☐ Optional Entity Liability
     - ☐ Optional Employment Practices Liability
     - ☐ Optional Third Party Liability
   - ☐ Fiduciary Liability
     - ☐ Optional Separate Defense Costs Coverage
   - ☐ Crime
   - ☐ Kidnap/Ransom & Extortion
   - ☐ Outside Directorship Liability (additional applications are required)
   - ☐ Supplemental Regulatory Coverage (an additional application is required)

2. **Applicant's** total revenue as of the most recent fiscal year end: $_____

3. **Applicant's** total assets as of the most recent fiscal year end: $_____

4. Cash flow from operations as of the most recent fiscal year end: $_____

5. Has the **Applicant** in the past twelve (12) months completed or agreed to, or does it contemplate during the next twelve (12) months, any of the following, whether or not such transactions were or will be completed:

   a) Reorganization or arrangement with creditors under federal or state law? ☐ Yes ☐ No

   b) Branch, location, facility, office, or subsidiary closings, consolidations or layoffs? ☐ Yes ☐ No

   c) Mergers and/or acquisitions? ☐ Yes ☐ No

   d) Entering into new governmental contracts? ☐ Yes ☐ No

   e) Conversion from non-profit to for-profit status? ☐ Yes ☐ No

   f) Undertaking new areas of business? ☐ Yes ☐ No

   If "Yes" to any part of Question 5, please describe the essential terms of each such transaction as an attachment.

III. DIRECTORS AND OFFICERS LIABILITY INFORMATION:

1. In the next twelve (12) months (or during the past twelve (12) months) is the **Applicant** contemplating (or has the **Applicant** completed or been in the process of completing) any public or private offering of securities or issuance of debt? ☐ Yes ☐ No

   If "Yes," please attach a full description of the details, including a copy of any prospectus.

2. a) Over the past twelve (12) months, has there been any change in the board of directors? ☐ Yes ☐ No

   b) Current number of: members on board of directors; trustees; member managers; or equivalent _____

   c) Current total outstanding shares, units, or interest _____

   If "Yes" to Question 2(a) above, please explain: _____

3. Please list all non-director and non-officer shareholders who directly or beneficially hold common stock and the percentage owned by each (if none, so indicate).

   Non director or non officer shareholders: Number of voting shares owned:

   _____ _____

   _____ _____

4. Does the **Applicant** now have tax exempt status under applicable federal, state and local law, including the U.S. Internal Revenue Code of 1986, as amended? ☐ Yes ☐ No

   If "Yes," is any challenge to the **Applicant's** tax-exempt status pending or anticipated by any party, private or governmental? ☐ Yes ☐ No

   If "Yes," please explain: _____

5. Has there been any change in the **Applicant's** ownership structure within the last 12 months? ☐ Yes ☐ No

   If "Yes," attach a full description of ownership structure.

6. a) Within the last two (2) years has the **Applicant** closed or restricted staff admissions of a provider to any patient service department for reasons other than professional competence, including but not limited to a conflict of interest? ☐ Yes ☐ No

   If "Yes," how many? _____

   b) Are there any formal plans for future closings or restrictions? ☐ Yes ☐ No

   If "Yes," provide details by separate attachment.

7. Over the past twelve (12) months has **Applicant** entered into any exclusive contracts with any providers? ☐ Yes ☐ No

   If "Yes," provide details by separate attachment.

8. Over the past twelve (12) months has **Applicant** controlled more than twenty percent (20%) in any given geographical area of:

   (a) providers in any given field of practice; (b) hospital beds; (c) health care services; or (d) if the **Applicant** provides managed care products or services, the market share of health plan members? ☐ Yes ☐ No

   If "Yes" to Question 8(a), (b), (c) and/or (d), please provide market share percentages by separate attachment.

IV. EMPLOYMENT PRACTICES INFORMATION:

1. Employee & Independent Contractor count: **Current Year**

   (a) Full-time employees: _____

   (b) Part-time employees (include leased and seasonal): _____

   (c) Volunteers: _____

   (d) Employed Physicians: _____

   (e) Independent Contractors: _____

   (f) Employees located in California: _____

2. Within the last year has the **Applicant** updated its employment practices handbook, or human resources policies and procedures or department? ☐ Yes ☐ No

   If the **Applicant** answered "Yes," please attach a copy of updated materials and a description of changes.

3. Number of employees who have left the **Applicant** over the past 12 months:

   Voluntary _____ Involuntary _____

V. FIDUCIARY LIABILITY COVERAGE INFORMATION:

1. Please list the names and types of **Applicant's** employee benefits plan(s)

Plan names (Do not include health & welfare plans)	**Plan assets** (current year)	**Plan assets** (previous year)	**Type of plan***	**Underfunded by more than 25%?** (DB only)	**Number of plan participants**

* Defined Contribution (DC), Defined Benefit (DB), Employee Stock Ownership (ESOP), Excess Benefit or Top Hat (EBP)

2. In the next 12 months is the **Applicant** contemplating (or has the **Applicant** completed within the last year) merging or terminating any plan(s)? ☐ Yes ☐ No

   If "Yes," please explain: _____

VI. CRIME COVERAGE INFORMATION:

1. Does the **Applicant** allow the employees who reconcile the monthly bank statements to also sign checks or handle deposits? ☐ Yes ☐ No

   If "Yes," please explain: _____

2. Does the **Applicant** have procedures in place to verify the existence and ownership of all new vendors prior to adding them to the authorized master vendor list? ☐ Yes ☐ No

3. Does the **Applicant** verify invoices against a corresponding purchase order, receiving report and the authorized master vendor list prior to issuing payment? ☐ Yes ☐ No

4. How often does the **Applicant** perform a physical inventory check of stock and equipment? _____

5. What is the limit above which the **Applicant** requires countersignature for their checks? $_____

VII. KIDNAP/RANSOM & EXTORTION COVERAGE INFORMATION:

1. Please complete the following information regarding the foreign travel of the **Applicant's** employees:

Travel destination by country	Number of annual trips	Average length of stay	Number of employees traveling

2. Describe the **Applicant's** security precautions taken for foreign travel: _____

3. Does the **Applicant** have a nursery, pediatric floor and/or an on-site child care/day care center? ☐ Yes ☐ No

   If "Yes," provide a brief description by separate attachment of the security measures used to ensure their safety.

VIII. MATERIAL CHANGE:

If any information provided in this Renewal Application changes materially before the policy inception date, the **Applicant** must immediately notify the Company in writing, and any outstanding quotation may be modified or withdrawn.

IX. DECLARATIONS, FRAUD WARNINGS AND SIGNATURE:

The **Applicant's** submission of this Renewal Application does not obligate the Company to issue, or the **Applicant** to purchase, a policy. The **Applicant** will be advised if the Renewal Application for coverage is accepted. The **Applicant** hereby authorizes the Company to make any inquiry in connection with this Renewal Application.

The undersigned authorized agent of the person(s) and entity(ies) proposed for this insurance declares that to the best of his or her knowledge and belief, after reasonable inquiry, that the statements made in this Renewal Application and in any attachments or other documents submitted with this Renewal Application are true and complete. The undersigned agrees that this Renewal Application, such attachments and other documents, and all other signed applications submitted by the **Applicant** to the Company for the proposed insurance or any other insurance contract of which the proposed insurance is a direct or indirect renewal or replacement shall be the basis of the insurance policy should a policy providing the requested coverage be issued; that all such materials shall be deemed to be attached to and shall form a part of any such policy; and that the Company will have relied on all such materials in issuing any such policy.

The information requested in this Renewal Application is for underwriting purposes only and does not constitute notice to the Company under any policy of a Claim or potential Claim.

Notice to Arkansas, Louisiana, Maryland, Minnesota, New Mexico and Ohio Applicants: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory agencies.

Notice to District of Columbia Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Notice to Florida and Oklahoma Applicants: Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of: a felony (in Oklahoma) or a felony of the third degree (in Florida).

Notice to Kentucky Applicants: Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

Notice to Maine, Tennessee, Virginia and Washington Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to Oregon and Texas Applicants: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Notice to Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to Puerto Rico Applicants: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Notice to New York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to: a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

This Renewal Application must be signed by the chief executive officer and chief financial officer of the Parent Organization acting as the authorized representatives of the person(s) and entity(ies) proposed for this insurance.

Date	Signature*	Title
_____	_____	Chief Executive Officer

X. PLEASE ATTACH A COPY OF THE FOLLOWING REQUIRED INFORMATION FOR EVERY APPLICANT SEEKING COVERAGE:

- ☐ Most recent annual financial statements, audited if outside audits are performed;
- ☐ When requesting Executive Liability coverage, board or directors, trustees, managers or equivalent listing;
- ☐ Most recent audited pension financial statements for each defined benefit plan (applicable to Fiduciary Liability coverage only);
- ☐ Copy of employee handbook (applicable when requesting Employment Practices Liability coverage).

Produced By:

Agent: _____ Agency: _____

Agency Taxpayer ID or SS No.: _____ Agent License No.: _____

Address: _____

City: _____ State: _____ Zip: _____

Submitted By:

Agency: _____

Agency Taxpayer ID or SS No.: _____ Agent License No.: _____

Address: _____

City: _____ State: _____ Zip: _____

SERFF Tracking Number:	*CHUB-125611628*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#370190 $70*
Company Tracking Number:	*DO AR0040510F01*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1006 Directors & Officers Liability*
Product Name:	*Health Care Portfolio*		
Project Name/Number:	*HCP/405*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CHUB-125611628*	*State:*	*Arkansas*
Filing Company:	*Federal Insurance Company*	*State Tracking Number:*	*#370190 $70*
Company Tracking Number:	*DO AR0040510F01*		
TOI:	*17.1 Other Liability - Claims Made Only*	*Sub-TOI:*	*17.1006 Directors & Officers Liability*
Product Name:	*Health Care Portfolio*		
Project Name/Number:	*HCP/405*		

Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-Property & Casualty

Review Status: Approved 05/23/2008

Comments:

Attachments:

AR NAIC form 405.pdf

AR NAIC schedule 405.pdf

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only

2. Insurance Department Use only	
a. Date the filing is received:	
b. Analyst:	
c. Disposition:	
d. Date of disposition of the filing:	
e. Effective date of filing:	
New Business	
Renewal Business	
f. State Filing #:	
g. SERFF Filing #:	
h. Subject Codes	

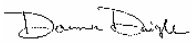
3.	Group Name	Group NAIC #
	Chubb Group of Insurance Companies	0038

4.	Company Name(s)	Domicile	NAIC #	FEIN #	State #
	Federal Insurance Company	IN	20281	13-1963496	

5.	Company Tracking Number	DO AR0040510F01

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Donna M. Daigle 82 Hopmeadow St., P.O. Box 2002 Simsbury CT 06070-7683	State Filing Analyst	800-464-7965	860-408-2047	ddaigle@chubb.com

7.	Signature of authorized filer	
8.	Please print name of authorized filer	Donna M. Daigle

Filing Information (see General Instructions for descriptions of these fields)

9.	**Type of Insurance (TOI)**	17.0000
10.	**Sub-Type of Insurance (Sub-TOI)**	17.0006
11.	**State Specific Product code(s) (if applicable) [See State Specific Requirements]**	N/A
12.	**Company Program Title** (Marketing Title)	HealthCare Portfolio
13.	**Filing Type**	☐ Rate/Loss Cost ☐ Rules ☐ Rates/Rules X Forms ☐ Combination Rates/Rules/Forms ☐ Withdrawal ☐ Other (give description)
14.	**Effective Date(s) Requested**	New: Upon approval Renewal:
15.	**Reference Filing?**	☐ Yes x No
16.	**Reference Organization** (if applicable)	N/A
17.	**Reference Organization # & Title**	N/A
18.	**Company's Date of Filing**	5/2/08
19.	**Status of filing in domicile**	☐ Not Filed X Pending ☐ Authorized ☐ Disapproved

Property & Casualty Transmittal Document

20.	**This filing transmittal is part of Company Tracking #**	DO AR0040510F01

21.	**Filing Description** [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

We are filing 2 new applications for this product. The product was approved by the Department effective September 22, 2004 under our filing designation number DO AR0023101F01

SERFF Tr Num: CHUB-125611628

22.	**Filing Fees** (Filer must provide check # and fee amount if applicable.) [If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: 00370190
Amount: 70.00

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)
(Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	DO AR0040510F01

2.	**This filing corresponds to rate/rule filing number** (Company tracking number of rate/rule filing, if applicable)	N/A

3.	**Form Name /Description/Synopsis**	**Form # Include edition date**	**Replacement Or Withdrawn?**	**If replacement, give form # it replaces**	**Previous state filing number,** if required by state
01	Health Care Portfolio for Physicians & Surgeons New Business Application	14-03-0967 (04/2008)	☒ New ☐ Replacement ☐ Withdrawn		
02	Health Care Portfolio for Physicians & Surgeons Renewal Business Application	14-03-0968 (04/2008)	☒ New ☐ Replacement ☐ Withdrawn		
03			☐ New ☐ Replacement ☐ Withdrawn		
04			☐ New ☐ Replacement ☐ Withdrawn		
05			☐ New ☐ Replacement ☐ Withdrawn		
06			☐ New ☐ Replacement ☐ Withdrawn		
07			☐ New ☐ Replacement ☐ Withdrawn		
08			☐ New ☐ Replacement ☐ Withdrawn		
09			☐ New ☐ Replacement ☐ Withdrawn		
10			☐ New ☐ Replacement ☐ Withdrawn		
11			☐ New ☐ Replacement ☐ Withdrawn		